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	085010	A. BUILDING _____ B. WING _____	C 01/23/2018

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F 000	INITIAL COMMENTS Text changes made to F684. An unannounced complaint investigation survey was conducted at this facility from January 11, 2018 through January 23, 2018. The facility census the first day of the survey was 127. The survey sample totaled eight residents. Abbreviations/definitions used in this report are as follows: AC or ac - before a meal; ADON - Assistant Director of Nursing; AP - Attending Physician; ASA - Aspirin; BMP - Basic Metabolic Panel/set of eight tests that measure blood sugar,calcium, kidney function, and chemical and fluid balance; BP - Blood Pressure/the pressure of the blood in the circulatory system, often measured for diagnosis since it is closely related to the force and rate of the heartbeat and the diameter and elasticity of the arterial walls; BUN - Blood Urea Nitrogen/blood test used to evaluate kidney function, to help diagnose kidney disease, and to monitor kidney dysfunction or failure; CBC with diff - Complete Blood Count with differential/blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia; cc - most commonly stands for "cubic centimeter" and is used as a shorthand code or abbreviation, when talking about doses of medication. One milliliter is equivalent to one cubic centimeter, or the volume inside a cube in which each edge measures one centimeter;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/25/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 CIC - Change in Condition/identified change in condition of the resident that may require notification to the attending physician or change in the plan of care; CIC Followup Note - clinical documentation of care and services provided to the resident by the nurse related to the identified CIC; CMP - Comprehensive Metabolic Panel/a panel of 14 blood tests which serves as an initial broad medical screening tool; c/o - complained of; CQS - Clinical Quality Specialist; DON - Director of Nursing; EMR - Electronic Medical Record; ER - Emergency Room; F - Fahrenheit/a temperature scale; FeSO4 - iron supplement; FSBS - fingerstick blood sugar testing; normal blood sugar levels for a fasting blood sugar test are 70 to 100 mg/dl; GFR - Glomerular Filtration Rate/blood test to measure your level of kidney function and determine your stage of kidney disease; HbA1C (A1C test) - blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months; HS or hs - hour of sleep/bedtime; IV - intravenous/within the veins or administration of medications/fluids through a tube directly into a vein; LPN - Licensed Practical Nurse; MAR - Medication Administration Record/facility documentation of all medications which are administered; MASD - Moisture Associated Skin Damage/prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus, saliva, and their	F 000		

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F 000	Continued From page 2	F 000		

contents. Characterized by inflammation of the skin, occurring with or without erosion or secondary cutaneous infection;
MD - Medical Director;
MDS - Minimum Data Set/standardized assessment forms utilized in nursing homes;
mg - milligram/metric unit of weight, 1 mg equals 0.0035 ounce;
mg/dl - milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid;
ml - milliliter;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
P - Pulse/a rhythmical throbbing of the arteries as blood is propelled through them, typically as felt in the wrists or neck;
PO or po - by mouth;
Pt - patient;
Q or q - every;
R or RR - Respiration/Respiratory rate/the number of breaths an individual takes per minute. The normal respiration rate for an adult at rest is 12 to 20 breaths per minute. A respiration rate under 12 or over 25 breaths per minute while resting is considered abnormal;
RN - Registered Nurse;
SSI - Sliding Scale Insulin/defined as a set of instructions for administering insulin dosages based on specific blood glucose readings;
SQ or sq - subcutaneous/situated or applied under the skin;
T - Temperature/the degree of internal heat of a person's body; average normal body temperature is an oral temperature (by mouth) of 98.6 F;
TAR - Treatment Administration Record;
TCU - Transitional Care Unit;
TID - three times a day;
U - Unit/Units; measurement of dosing for insulin;

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F 000	Continued From page 3 UA - urinalysis/Urine test used to detect a wide range of disorders, such as urinary tract infections, kidney disease and diabetes; UTI - Urinary Tract Infection/an infection involving the kidneys, ureters, bladder, or urethra; VS - Vital Signs/clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions. WBC - White Blood Cells/disease fighting cells called leukocytes; WNL - within normal limits; % - percent; X - times; @ - at; < - less than; > - greater than. Abscess - a collection of pus that has built up within the tissue of the body; Signs and symptoms include redness, pain, warmth, and swelling; Accucheck - brand name of a machine to check FSBS; Amoxicillin - an antibiotic; Atorvastatin - drug used to lower blood cholesterol; Augmentin - an antibiotic; Blanche - blanch or turn white when pressure is applied to a reddened area; Braden Scale - assessment tool used to determine risk for development of pressure ulcers; Buccal mucosa - the inner lining of the cheeks and lips; Butterfly Optifoam - a dressing for fluid handling; Chronic Kidney Disease - CKD/describes the gradual loss of kidney function; Cipro - Ciprofloxacin/an antibiotic;	F 000		

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F 000	Continued From page 4	F 000		

Cognition - mental processes or thinking;
Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently;
Congestive heart failure - a chronic progressive condition that affects the pumping power of your heart muscles;
Creatinine/creat - blood test that measures kidney function;
Dehydration - a harmful reduction in the amount of water in the body;
Diabetes Mellitus - (DM) commonly referred to as "diabetes", a chronic disease associated with abnormally high levels of the sugar glucose in the blood;
Dysuria - painful urination;
Eschar - hard dead tissue that is tan, brown or black. Eschar is worse than slough;
Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight - bearing support;
Flextouch - prefilled disposable insulin pen;
Glucose - sugar;
Hyperglycemia - high blood sugar level;
Hypoglycemia - low blood sugar level;
Humalog - rapid acting insulin;
Insulin - injectable medication used to control blood sugar levels;
Lantus - long acting insulin;
Lethargic - state of fatigue or sluggishness;
Levemir - long acting insulin;
Leukocytosis - high WBC cell count is an increase in disease-fighting cells circulating in

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F 000	Continued From page 5 your blood; Maceration - softening and whitening of skin by soaking in fluids; Medihoney - advanced wound care dressing; Moderate Cognitive Impairment - unable to make own decisions; Mucous membranes - membrane that lines various cavities in the body and surrounds internal organs; Neurological - having to do with the nervous system, includes the brain, spinal cord, and nerves; Normal saline solution - 0.9% strength of sodium chloride (salt) solution in water; Optilock - wound dressing that absorbs a remarkable amount of wound fluid; Oxybutynin Chloride ER (extended release) - medication to treat over active bladder; Oxygen saturation - a measure of how much oxygen the blood is carrying; Peri wound - the tissue surrounding a wound; Polyuria - a condition usually defined as excessive or abnormally large production or passage of urine; Pressure redistribution surface - alters the distribution of pressure; Pressure reducing device - a device which reduces pressure; Pressure ulcer or PU - sore area of skin that develops when the blood supply to it is cut off due to pressure; PU Stage II (2) - blister or shallow open sore with red/pink color; PU Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin; PU Stage IV (4) - open sore so deep that muscle, tendon or bone can be seen/felt; PU Unstageable - actual depth of the ulcer	F 000		

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F 000	Continued From page 6	F 000		

cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue);
Pulse oximetry - measures blood oxygen saturation levels/desired range 94% to 100%;
Remeron - an antidepressant medication;
Rocephin - an antibiotic;
Sacrum/sacral - a triangular bone at base of spine;
Santyl - an enzyme that breaks down collagen in damaged tissues within the skin and helps the body generate new healthy tissue;
Serosanguineous - containing or consisting of both blood and serous (thin, watery) fluid;
Shear/Friction - friction with reduced blood flow to the tissue under the skin from sliding down in, or being pulled across, the bed;
Skin prep - a liquid film-forming dressing that, upon application to intact skin, forms a protective film;
Slough - yellow, tan, gray, green or brown soft dead tissue;
Straight catheterization/cath - involves inserting and removing a catheter to empty bladder or to obtain a specimen;
Sodium - salt found in body;
Tissue - specialized living human cells;
Tunneling - passage underneath the skin;
Undermining - skin edges have lost contact with underlying tissue;
Urinary incontinence - loss of control of bladder function;
Urine C&S - urine Culture and Sensitivity/test used to diagnose which bacteria are causing infection and to determine which antibiotics are effective in killing the bacteria;
Urinary urgency - a sudden, compelling urge to urinate;
Vashe solution - wound irrigant;

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F 000	Continued From page 7 Wound bed - bottom of a wound; Wound cleanser - non-irritating formulation that aids in the removal of foreign materials such as dirt and debris from wounds;	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		3/19/18

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F 580	Continued From page 8 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family interviews, and staff interviews, it was determined that for one (R1) of three sampled residents, the facility failed to immediately notify R1's involved family members, when significant changes to R1's medication treatment plans were made. Findings include: Cross-refer F684, example 1a. The following was reviewed in R1's clinical record: 6/21/17 and untimed order - written by E5 (NP2), stated: -HbA1c on 12/15/17. -Discontinue Atorvastain, discontinue Fish oil, discontinue FeSo4, discontinue SSI, discontinue Humalog 4 units SQ TID with meals, UA and urine C&S (may straight cath for results), discontinue ASA 81 mg., consult dentist for macerated left gum.	F 580	1. R1 was a Hospice resident who no longer resides at the center since 9/9/2017. The family requested medication and treatment changes to be completed at the discretion of the physician after a special care conference was held. The center informed the family. 2. Residents who have medication and or treatment changes could potentially be affected. Current residents medical records have been reviewed from 2/1/18 to current to determine appropriate notifications were completed for significant changes to medications and/or treatments. 3. Root Cause: The practitioner should have called the family and reviewed what specific medication and treatment changes were completed per their request	

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F 580	Continued From page 9 Although both FM1 and FM2 (R1's family members) were identified in the clinical record, as R1's healthcare decision makers, record review lacked evidence that either was notified by the facility about the significant changes in R1's medication treatment plan. 1/12/18 at approximately 10:25 AM - An interview with FM1, confirmed FM1 was not informed of the above changes to R1's treatment plan. 1/16/18 at approximately 3:00 PM - An interview with E5 (NP2) confirmed the above 6/21/17 orders were written prior to discussing the alteration in care with FM1 or FM2. 1/24/18 at approximately 3:25 PM - An interview with FM2, confirmed FM2 was not informed of the above changes to R1's treatment plan. Findings reviewed on 1/24/18 at approximately 4:15 PM with E1 (NHA), E2 (DON), E3 (CQS) and E7 (ADON).	F 580	to the care plan team. Center nurse leadership to include the Center Nurse Executive (DON) and Unit Managers, will review order changes within 72 hours of orders written and review documentation for evidence of resident and/or responsible party notification. Licensed staff will be responsible to notify family, responsible party, and/or resident. Licensed nursing staff will be educated on or before March 14, 2018 on policy NSG 122 Change in Condition: Notification of. 4. The center's CNE/ADON/UM's will randomly review 10% of census daily to determine resident and/or responsible party notification of medication and/or treatment changes until three consecutive reviews achieve 100% accuracy, then 3 times per week until 3 reviews achieve 100% accuracy, then weekly until 3 consecutive reviews achieve 100% accuracy, then monthly for three months until 3 reviews achieve 100% compliance. The CNE will report results to the QAPI committee monthly and the committee will provide further recommendations for sustainability of the plan. If 100% compliance is maintained, the issue will be removed from QAPI.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		3/19/18

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F 656	Continued From page 10 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R2) out of three sampled	F 656	1. R2 care plan has been developed for actual skin break down on 1/22/18.	

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F 656	Continued From page 11 residents with pressure ulcers (PU), the facility failed to develop a care plan for an identified need. Findings include: Cross refer F686, examples 1a. Review of R2's clinical record revealed: 10/11/17 - Readmitted to the facility from the hospital. 10/11/17 - Readmission Nursing Assessment documented that R2 had a stage II PU of the sacrum. 10/11/2017 - A care plan (revision date of 10/11/17, with initial created date of 6/7/17) for risk of skin breakdown was completed. Although R2 was readmitted with an actual PU of the sacrum, record review lacked evidence of an care plan. 12/27/17 - R2 readmitted to the facility after hospitalization. 12/27/17 - Skin Integrity Report documented an unstageable PU in the sacral area upon readmission. 1/23/18 at approximately 3:00 PM - An interview with E2 (DON) confirmed the facility had no evidence of an actual care plan for the sacral PU. Findings reviewed on 1/24/18 at approximately 4:15 PM with E1 (), E2, E7 (ADON), and E3 (CQS).	F 656	2. Root Cause: The nurse did not initiate an accurate care plan according to center policy. The resident continued to receive care and treatment for the sacral PU despite the care plan. Current residents with actual pressure ulcers were reviewed to determine that an actual skin care plan was initiated and/or revised to reflect the residents' current status. 3. The Nurse Practice Educator will educate licensed nursing staff on or before March 19, 2018, on OPS 416 Person Centered Care Plan Policy and Procedure. This includes but not limited to informing nurses of the requirement for Comprehensive Care Plan development according to F656. 4.The center's CNE/ADON/UM's will review every new admission/readmission for skin assessments and appropriate skin care plan development according to the needs of the resident. This will be an ongoing process at each clinical morning meeting Monday through Friday for the next 3 months. The CNE will report results to the QAPI committee monthly and the committee will provide further recommendations for sustainability of the plan. If 100% compliance is maintained, the issue will be removed from QAPI.	
F 684	Quality of Care	F 684		3/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684 SS=E	Continued From page 12 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of other facility documentation as indicated, it was determined that the facility failed to provide the care and services necessary to promote the highest level of well-being for one (R1) out of 6 sampled residents. The facility erroneously discontinued FSBS testing for R1, a diabetic resident receiving daily insulin, resulting in a lack of monitoring and assessment of R1's blood sugar values from 6/28/17 through 8/8/17. On 7/11/17, R1's long acting insulin (Levemir) was discontinued resulting in R1's having no insulin and no monitoring of blood sugar values through 8/8/17. During this time frame, R1 experienced infectious processes, specifically a UTI and a dental abscess, which had the potential to affect R1's blood sugar values. R1 was found lethargic with a blood sugar value of 484 (normal range 70-100 mg/dl) on 8/8/17. Additionally, for R1 with a known history of urinary tract infections (UTI), the facility failed to ensure the completion of testing for a UTI (UA and urine C&S). For R3, a known insulin dependent diabetic, the facility failed to monitor blood sugar values via FSBS. Findings include:	F 684	1. R1 No longer resides at the center since 9/9/2017 R3 no longer resides at the center since 2/10/2018. The center has no ability to correct for R1, and R3 had FSBS initiated on 1/20/2018. 2. Root Cause: One center physician was copying and pasting notes from a previous visit which led to erroneous documentation of the resident. The center was transitioning to a new Medical Director and the POS was not signed timely. Physician was unaware that ordered lab was not obtained. Current POS's will be reviewed by March 19, 2018. A. Insulin and FSBS orders were not clear when written together. Center reviewed resident records during the survey of those who have a diagnosis of Diabetes Mellitus to determine current orders are in place for glucose monitoring and diabetic management. Review confirmed by surveyor. B. CIC(s) are being reviewed at each clinical meeting to determine	

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	085010	A. BUILDING _____ B. WING _____	C 01/23/2018

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F 684	Continued From page 13 Levemir's manufacturer package insert states, "...Warnings and Precautions...Dose adjustment and monitoring: Monitor blood glucose in all patients treated with insulin. Insulin regimens should be modified cautiously and only under medical supervision...Dosage and Administration:...The dose of Levemir must be individualized based on clinical response. Blood glucose monitoring is essential in all patients receiving insulin therapy...Patient Information:...Check your blood sugar levels...". According to the National Institute of Diabetes and Digestive and Kidney Diseases The A1C (HbA1C) Test & Diabetes states, "...The A1C test is a blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months...Large changes in a person's blood glucose levels over the past month will show up in their A1C test result, but the A1C does not show sudden, temporary increases or decreases in blood sugar levels...". (https://www.niddk.nih.gov/health-information/diabetes/overview/tests-diagnosis/a1c-test). The following was reviewed in R1's clinical record: 3/17/17 - R1 was admitted from the hospital following treatment for a broken left lower leg and treatment of a UTI that required administration of IV antibiotics. R1 had diagnoses including congestive heart failure and type II diabetes mellitus requiring daily administration of insulin. 1a. DIABETES MANAGEMENT: 3/20/17 - A care plan for insulin dependent	F 684	documentation for monitoring and assessing residents, including vital signs, are initiated and/or completed. C. NEW PROCESS: A summary of labs obtained will be provided to the physician and physician extenders daily for 60 days for their review. D. 24 Hour Chart Checks were not completed and/or transcribed to the MAR or TAR and to the lab log as required. 3. The following will be performed on or before March 19, 2018: A.Center attending physician's, physician extenders, and licensed nursing staff were educated by the Medical Director and/or the NPE on the practice of orders for monitoring Glucose per patients needs. NEW PROCESS: Physician, physician extenders, and Licensed nurses will be educated by the NPE that FSBS and Insulin orders shall be written as two separate provider orders. B. Licensed nurses will be educated on or before March 19, 2018 on inclusion of vital signs for significant changes in condition. C. NPE to educate license nurses on the revised lab log, adding new orders to the lab log, and completing lab requisitions. D. Licensed nurses will be educated by the NPE on the center process of the policy NSG 251 titled 24 Hour Chart Check. 4. The CNE/ADON/UM's will review 20% of medical records at clinical morning meetings for copies of new orders to determine	

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F 684	Continued From page 14 diabetic, (most recent revision date of 9/6/17), included a goal that R1 will be free of all signs and symptoms of hypo/hyperglycemia such as sweating, trembling, thirst, fatigue, weakness, and blurred vision for the next 30 day period of time. Interventions included: -Access and record blood glucose levels as ordered; -Monitor meal consumption each meal; -Labs as ordered and report results. 5/2/17 - A Progress Note completed by E15 (AP1), documented R1 was alert, awake and oriented to person, place, and time, had no complaints and no further increase in urinary incontinence, dysuria, urgency, frequency or polyuria and had stable blood sugars and blood pressure. 6/2017 - Monthly Physician's Order Form documented the following insulin regimen to treat diabetes mellitus:: - Humalog 100 units/1 ml, inject SQ per sliding scale and to check blood sugar before meals and at bedtime. - Humalog 4 units SQ three times a day with meals. - Levemir flextouch 100 unit/1 ml, inject 20 units SQ Q AM. - Levemir 8 Units Q HS. 6/2/17 and timed 2:32 PM - A Change of Condition (CIC) Progress note, completed by E11 (LPN), documented the onset of dysuria beginning on the afternoon of 6/2/17. VS taken on 6/2/17 at 2:35 PM were BP 122/64, P 80, R 18, T of 97.8 F. 6/13/17 - Quarterly MDS Assessment	F 684	A. Insulin orders,FSBS orders are written separately B. Vital signs are completed for significant CIC'(s). C. Lab logs are reviewed to determine labs are completed as ordered. D. Record review for completion of 24 Hour chart check to include transcription of new orders. These audits will be completed until three consecutive reviews achieve 100% accuracy, then three times per week until three consecutive reviews achieve 100% accuracy, then weekly until 3 consecutive reviews achieve 100% accuracy, then monthly times three months until reviews achieve 100% accuracy. The CNE(DON) will report findings to the QAPI committee monthly for further evaluations and recommendations to determine sustainability. If the center achieves 100% compliance this will be removed from monthly QAPI.	

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F 684	Continued From page 15 documented R1 was moderately impaired with daily decision making, required extensive assistance of one staff's physical assistance for bed mobility, personal hygiene, dressing, and toileting. 6/15/17 - R1's HbA1C result equaled 6.7 (normal range 4.0-6.0). 6/21/17 and timed 3:18 PM - A Follow-up Progress Note, completed by E5 (NP2), notes changes to R1's plan of care as follows: -Discontinue routine Humalog insulin three times a day with meals; -Discontinue the SSI; -Accuchecks every AM and PM. 6/21/17 and untimed order - completed by E5, documented the following: -HbA1C on 12/15/17; -Discontinue SSI, discontinue Humalog 4 units SQ TID with meals. Review of these orders revealed that despite having written in the 6/21/17 follow up progress note, E5 failed to include in the order for R1 to have accuchecks completed every AM and PM. Further review of the order revealed that it was not noted and transcribed by the nursing staff until 6/28/17, seven days later. As a result of the order being missed on 6/21/17, R1 continued to have FSBS completed before meals and at bedtime, and continued to receive SSI coverage and Humalog 4 Units before meals through 6/28/17. 6/22/17 through 6/28/17 -Review of the MAR revealed that the medications Atorvastatin, Fish Oil, FeSo4, ASA, Humalog 4 units three times a day with meals and SSI coverage before meals	F 684		

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F 684	Continued From page 16 and at bedtime were signed off as given. 6/26/17 - A 30 day Follow-up Note, completed by E5, documented that glucose on 6/26/17 was 140 @ 6 AM. The note continued to document FSBS every AM and PM, medication reviewed and reconciled with chart, reviewed medical records, labs and testing. 6/28/17 - E5's order, dated 6/21/17, revealed a notation by E10 (LPN) that the order was "pulled and faxed 6/28/17." Although E5's 6/21/17 order was missed for a total of seven days there was no evidence that the facility informed or consulted with E5. 6/28/17 - Review of the MAR revealed that blood sugar checks before meals and at bedtime for R1 were discontinued beginning 6/28/17 at 4:00 PM. There was no evidence that the facility questioned the discontinuation of all monitoring of R1's blood sugars. 7/2017 - Monthly Physician's Order Form documented the following: - Levemir flextouch 100 unit/1 ml, inject 20 units q AM; - Levemir 8 Units q HS. These orders were reviewed by E10 on 6/28/17 and not signed by E5 until 8/4/17. 7/8/17 and timed 2:46 PM - A Skilled Nursing Note stated, "Skilled Services: ...skilled nursing observation for UTI and fall" by E17 (RN). This note documented a comprehensive physical assessment of R1. The note documented R1 had no complaints of dysuria, but had one episode of vomiting, ginger ale was given, and R1 continued to complain of nausea and E4	F 684		

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F 684	Continued From page 17 (Medical Director) was notified. 7/8/17 and timed 9:45 PM - An order for Zofran 4 mg IM (intramuscular) X 1 dose for nausea and vomiting. 7/11/17 and timed 1:35 PM - A 30 day Follow-Up Note completed by E5, documented follow-up related to diabetes and the plan was to discontinue Levemir insulin and discontinue Accucheck. Reviewed medical records, labs and testing. Although this note documented to discontinue Accuchecks, FSBS had not been done since the order was incorrectly discontinued on 6/28/17. 7/11/17 and timed 4:00 PM - An order written by E5 stated to discontinue Levemir insulin, discontinue Accuchecks. The facility again failed to clarify the order, as accuchecks not not being completed for R1 since 6/28/17. 8/8/17 and timed 10:46 PM - A CIC Note written by E18 (LPN) for a CIC the morning of 8/8/17 in which FSBS was high at 453 in the morning. VS taken on 8/8/17 at 10:46 PM BP 126/81 P 96 with regular rate, R 18, T of 96.8 F. E4 (MD) was notified at 8:00 AM. 8/8/17 and timed 10:59 PM - A General Progress Note completed by E18 documented R1 was noted to be lethargic and had generalized weakness at 8:30 AM. Vital signs assessed and stable. FSBS obtained 453. E4 notified with new orders for Humalog 10 units x 1. FSBS re-checked at 9:30 AM and it was 389. NP aware. FSBS re-checked at 12:00 PM and it was 484. New order for additional 10 units of Humalog.	F 684		

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F 684	Continued From page 18 FSBS ac and hs with sliding scale insulin and Lantus 10 units daily at hs. Although E18 documented VS assessed and stable, record review lacked evidence of a comprehensive assessment of R1 who was in a hyperglycemic state including full set of VS, oxygen saturation and skilled nursing assessment. 8/8/17 and timed 9:00 AM - R1's MAR documented administration of Humalog 10 Units given. 8/8/17 and timed 12:00 PM - R1's MAR documented administration of an additional Humalog 10 Units given. 8/8/17 and timed 7:35 PM -A Progress Note completed by E5 stated that R1 was seen due to hyperglycemia, resident lethargic this AM and blood sugar was >400. Initiate Lantus 10 sq daily, FSBS AC and HS with SSI. 8/8/17 and timed 1:00 PM - An order written by E5 stated to give Humalog 10 Units now x1 dose, Lantus 10 units SQ Q HS and FSBS AC & HS with SSI Humalog insulin. 8/8/17 - An order was written for a BMP in AM. 8/9/17 and 8/10/17 - R1's BMP results for glucose results were 215 and 275 respectively 1/16/18 at approximately 3:00 PM - An interview with E5 revealed that she had documented in her progress note to discontinue the SSI and to initiate FSBS Q AM and PM. E5 confirmed, after review of the closed records, that there was no	F 684		

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F 684	Continued From page 19 order written for checking FSBS Q AM and PM when the order to discontinue SSI was written on 6/21/17. 1/16/18 at 12:05 PM - An interview with E2 (DON) was conducted. Surveyor inquired, if when an order was written to discontinue SSI, should the facility have discontinued the SSI as well as FSBS before meals and at bedtime. E2 reviewed the June Physician's Order Form and verbalized that if she had obtained the discontinue SSI order, she would need to contact the attending physician to clarify whether both the SSI and FSBS checks are to be discontinued. 1/16/18 at 1:45 PM - An interview with E10 revealed that E10 found handwritten orders dated 6/21/17 and untimed in R1's chart on 6/28/17 and pulled the orders and faxed the orders to pharmacy. When asked about the order to "discontinue the SSI", E10 interpreted this as discontinuing both the SSI and checking the FSBS. 1/18/18 at approximately 1:00 PM - An interview with E4 (Medical Director) was conducted and E4 was asked to review the 6/21/17 order to discontinue SSI and not to discontinue checking the FS before meals and bedtime for R1. E4 stated that there was a meeting related to this issue with R1's family members (FM1 and FM2) and that the providers in her practice have been educated to ensure all residents with a diagnosis of diabetes mellitus, be monitored via checking FSBS in addition to the HbA1C. E4 relayed that this expectation was not communicated to other providers, such as those providing medical care through a managed care program, however, communication had taken place during the survey	F 684		

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F 684	Continued From page 20 on 1/13/18. 1/23/18 at approximately 3:15 PM - An interview with E2 revealed that the facility had re-written all residents orders which included both SSI and checking FSBS into two separate and distinct orders. Additionally, all residents with diabetes currently have an individualized order to check FSBS. The facility failed to follow the order to discontinue SSI and discontinued the SSI and the checking of the FSBS. This lack of checking the FSBS beginning on 6/28/17 to 8/8/17 resulted in R1 being found lethargic with hyperglycemia at 453. Due to lack of monitoring of BS, it is unclear how long R1 was in a hyperglycemic state. The facility erroneously discontinued FSBS testing for R1, a diabetic resident receiving daily insulin, resulting in a lack of monitoring and assessment of R1's blood sugar values from 6/28/17 through 8/8/17. On 7/11/17, R1's long acting insulin (Levemir) was discontinued resulting in R1's having no insulin and no monitoring of blood sugar values through 8/8/17. During this time frame, R1 experienced infectious processes, specifically a UTI and a dental abscess (for which a dental consult was not implemented), which had the potential to affect R1's blood sugar values. R1 was found lethargic with a blood sugar value of 453 (normal range 70-100 mg/dl) on 8/8/17 that later after 4 hours went up to 484. 1b. POSSIBLE INFECTION/INFECTION/TREATMENT WITH ANTIBIOTIC:	F 684		

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F 684	Continued From page 21 3/23/17 - An order was written for VS daily. 5/2/17 - A progress note completed by E15 (AP1), documented R1 was alert, awake and oriented to person, place, and time, had no complaints and no further increase in urinary incontinence, dysuria, urgency or frequency. 5/16/17 - R1's laboratory results documented WBC of 10.3 (normal range 4.8 - 10.8). In addition, glucose, BUN, sodium, and creatinine were all within normal ranges. The GFR estimation of 67.8, indicated stage II kidney disease and a mild decrease in GFR (range for stage II disease is 60-89). 6/17 - A monthly Physician's order form documented the following: -Vital signs with the term "daily" crossed off by E10 (LPN), who reviewed the monthly orders on 5/31/17. There was no evidence that an order had been written to discontinue daily VS. 6/1/17 - Quarterly MDS Assessment documented R1 was moderately impaired with daily decision making, required extensive assistance of one staff's physical assistance for bed mobility, personal hygiene, dressing, and toileting. 6/2/17 - An order was written for a UA and urine C&S for dysuria by E16 (NP1). 6/2/17 and timed 2:32 PM - A CIC progress note, completed by E11 (LPN), documented R1's onset of dysuria on the afternoon of 6/2/17. VS taken on 6/2/17 between 2:34 PM and 2:35 PM were BP 122/64, P 80, R 18, T of 97.8 F. 6/2/17 and timed 7:20 PM - A General Progress	F 684		

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F 684	Continued From page 22 Note, completed by E17 (RN), documented R1 was found sitting on the floor in front of her wheelchair and assessment revealed no apparent injury, neurological VS were completed and within normal limits. 6/3/17 - UA results documented abnormal findings. 6/6/17 - The urine C&S results indicated R1 had a UTI and an order was written for R1 to receive Cipro 250 mg. by mouth, twice a day X 7 days. 6/6/17 and timed 2:28 PM - A CIC Note, completed by E11, documented that the resident had a new diagnosis of UTI on the morning of 6/3/17. VS taken on 6/6/17 between 2:29 PM and 2:30 PM were BP 102/72, P 74, R 18, T of 96.6 F. 6/13/17 and timed 2:27 PM - A Follow-Up Progress Note, written by E5, documented R1 denied dysuria and had polyuria. E5 documented that the last day of Cipro was 6/13/17. The note stated that a UA and urine C&S in AM would be ordered due to R1's complaint of urinary urgency. 6/13/17 and timed 4:30 PM - An order was written by E5 to increase oxybutynin chloride ER to 15 mg. by mouth twice a day, and to obtain a UA with urine C&S in the AM. 6/14/17 - The UA results documented abnormal findings. 6/15/17 - The urine C&S results documented, "mixed culture greater than 3 organisms (indicating the sample was contaminated), please repeat." Record review lacked evidence that a follow-up order was written to repeat the Urine	F 684		

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F 684	Continued From page 23 C&S, as recommended on the 6/15/17 laboratory results. 6/21/17 and untimed - An order written by E5, documented the following: - UA and urine C&S may straight catherize for results. This order was not noted by the facility until 6/28/17, seven days later resulting in a delay of obtaining results and a delay in need for treatment. 6/21/17 and timed 3:18 PM - A Follow-Up Progress Note, written by E5, documented chief complaint/nature of presenting problem due to R1 noted swelling to left cheek. 6/21/17 and timed 3:19 PM - An order was written by E5, for R1 to receive a swab and rinse treatment to the left gum three times a day and to receive an antibiotic every 8 hours for 3 days for a dental abscess. 6/21/17 and timed 2:04 PM - A CIC Note, written by E17, documented swelling to left side of face, with mucous membranes that were macerated and discolored on the morning of 6/21/17. VS taken on 6/21/17 between 10:12 AM to 10:19 AM were BP 140/87, P 78, R18, T of 97.8 F. 6/21/17 and timed 3:18 PM - A Follow-up Progress Note, written by E5, stated changes in R1's plan of care to include UA and urine C&S in AM due to patient complaints of urinary urgency. 6/26/17 - A 30 day Follow-up Note, completed by E5, documented under the plan of care, UTI-UA and urine C&S pending. The note documented medical records, labs and testing were reviewed.	F 684		

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F 684	Continued From page 24 7/2017 - A monthly Physician's Order Form documented the following: -Vital Signs daily (initial order date of 3/23/17). These orders were reviewed by E10 on 6/28/17 and signed by E5 on 8/4/17. Although VS were ordered to be completed daily, record review revealed that temperatures were not taken on 7/1/17, 7/2/17, 7/4/17, 7/5/17, and 7/7/17. 7/8/17 and timed 2:46 PM - A Skilled Nursing Note stated, "Skilled Services: ...skilled nursing observation for UTI and fall" by E17. This note documented a comprehensive physical assessment of R1. The note documented R1 had no complaints of dysuria, had one episode of vomiting, ginger ale was given, but the patient continued to complain of nausea and E4 was notified. 7/8/17 and timed 9:45 PM - An order was written for R1 to receive Zofran 4 mg po X 1 dose. 7/11/17 and timed 1:35 PM - A 30 day Follow-Up Note, written by E5, documented follow-up on the dental abscess and diabetes. R1 denied dysuria and admits to polyuria. The left cheek with swelling, inflammation and maceration improved and to continue with the mouth rinse and consult with dental for the abscess. . 7/11/17 and timed 4:00 PM. - An order was written by E5, for R1 to receive Augmentin 875/125 po Q 12 hr x 7 days for dental abscess. 7/13/17 and timed 2:46 PM - A Skilled Nursing Note stated, "Skilled Services: ...skilled nursing observation for UTI and fall" by E17. This note documented a comprehensive physical	F 684		

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F 684	Continued From page 25 assessment of R1. The note documented R1 had no complaints of dysuria. 8/2017 - The monthly Physician's Order Form documented the following: -Vital Signs daily (initial order date of 3/23/17). These orders were reviewed by E10 on 7/25/17 and signed by E5 on 8/2/17. 8/1/17 - Review of the clinical record revealed there were no VS recorded. 8/2/17-8/7/17 - VS were recorded revealing the following ranges: - BP 118/74 to 136/86; - P 70 to 96; - R 16 to 18; - T 96.8 to 98.8 F. 8/8/17 and timed 10:46 PM - A CIC Note written by E18 (LPN), for a CIC the morning of 8/8/17 in which R1's FSBS was 453. VS taken on 8/8/17 at 10:46 PM BP 126/81 P 96 with regular rate, R 18, T of 96.8 F. E4 was notified at 8:00 AM and FM1 notified at 4:00 PM. 8/8/17 - An order was written for a CBC with diff, and BMP in AM. Despite the fact the resident had a significant CIC, record review lacked evidence that the nursing staff identified or considered the need for adequate monitoring and assessment, including VS when R1 was in a lethargic state at 8:00 AM. 8/9/17 - R1's laboratory results revealed an elevated WBC of 15.8. Despite an elevated WBC, a usual indicator of	F 684		

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F 684	Continued From page 26 infection and an order for daily VS, record review lacked evidence of adequate assessment and monitoring, including monitoring of R1's temperature. 8/9/17 - The BMP laboratory results revealed an elevated glucose of 215, an elevated BUN of 41, as well as a GFR of 46.9 (indicating stage III CKD range 30-59). R1 was ordered an IV antibiotic daily for 6 days, in addition to IV fluids for a total of 2 liters to be infused, as well as repeating a CBC with diff & BMP in AM. 8/10/17 and timed 8:36 AM- R1's VS were recorded as BP 100/60, P 99, R18, T of 98.2 F. Record review lacked additional vital signs on 8/10/17 although R1's pulse was elevated and BP lower than her usual range. 8/10/17 - The CBC revealed an increase in the WBC to 17.0. The BMP results revealed an elevated glucose of 275, an elevated BUN of 44, and a GFR of 52.4 (indicating stage III CKD). 8/11/17 - An order was written for a repeat CBC and CMP in 1 week. 8/11/17 -8/14/17- Despite R1 receiving IV antibiotics and having an elevated WBC, the facility failed to complete a full set of VS when there were no temperatures monitored. 8/15/17 and timed 2:36 PM - A progress note completed by E19 (AP2) stated, "Patient states that she had tingling on urination with some discomfort last week now improved." "Plan:...Leukocytosis source ? possible urine based on clinical complaint. Resolved. Will	F 684		

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F 684	Continued From page 27 observe off antibiotic therapy. Dehydration: Resolved. Will encourage oral fluids. Keep water at bedside but < 1500 ml fluid restriction." 8/16/17 - The BMP laboratory results revealed that while R1's glucose level remained elevated, all other values were within normal range. In addition, the GFR was 79.1 (improved, but indicating stage II CKD). 8/17/17 and 3:16 PM - A progress note completed by E4, "Chief Complaint/Nature of Presenting Problem," documented, "...Pt had leukocytosis and also c/o dysuria so was started on IV Rocephin. Finished her course and has no dysuria and WBC down to WNL...Plan: 1.Leukocytosis- resolved after AB (antibiotic). Most likely source was UTI." 1/16/18 at approximately 3:00 PM - An interview was conducted with E5. The surveyor inquired, what provisions of care and services are provided by the staff, when R1 experienced CIC, such as when R1 was placed on an antibiotic treatment? E5 verbalized it was her understanding, when a CIC occurs, clinical assessment and monitoring was required for 72 hours including full set of vital signs per shift. 1/18/18 at approximately 1:00 PM - An interview with E4 was conducted. As the Medical Director, it was her expectation and understanding for CIC, such as a resident on an antibiotic, the facility would complete full set of vital signs, every 8 hours while the resident is on an antibiotic and additional duration and frequency to be determined by the medical practitioner. 1/23/18 at approximately 3:00 PM - An interview	F 684		

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F 684	Continued From page 28 with E2 (DON) was conducted. E2 stated that there was not a predetermined frequency and duration of monitoring, however, for those residents on antibiotic or who may have an infection, her minimum expectation would be obtaining a temperature. E2 indicated that the attending physician would order specific monitoring that would be required for each resident. In addition, E2 stated that each licensed nurse will utilize their own nursing judgement related to adequate monitoring. 1/23/18 at approximately 4:15 PM - During the exit meeting, E3 (CQS) confirmed there was no facility policy and procedure, with predetermined frequency and duration of monitoring for various CICs. E3 stated that by standards of practice, the expectation was that temperatures be taken while a resident was being treated with an antibiotic. The surveyor verbalized that R1's order for daily VS, including temperatures, was not followed from June 2017 through August 2017. The facility failed to repeat a urine C&S, as documented on the 6/15/17 urine C&S results. In addition, when the UA and urine C&S was ordered on 6/21/17 due to R1's symptom of urgency, the facility failed to ensure this testing was completed. The facility failed to complete adequate and comprehensive monitoring, including VS, which was ordered daily. These failures resulted in R1 being found lethargic with WBC of 15.8 and WBC 17.0 and likely a UTI. 2. Review of R3's clinical record revealed the following: 5/9/17 - R3 was admitted to the facility under a managed care program with diagnoses that	F 684		

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F 684	Continued From page 29 included diabetes mellitus requiring administration of insulin.. 1/2018 - The monthly Physician's Order Form documented the following: - Humalog 100 units/1 ml, inject SQ 4 units twice daily with lunch and dinner. - HbA1C every three months. There was no physician's order for monitoring of R3's blood sugars via FSBS. 1/13/18 at approximately 11:00 AM - An interview with E4 (MD) was conducted. E4 stated that following a meeting on 8/17/17 at the facility, providers in her practice were educated to ensure that all residents with a diagnoses of diabetes mellitus are monitored via an individually determined monitoring via FSBS in addition to the HbA1C. E4 stated that this expectation was not communicated to other providers, such as those providing medical care through a managed care program, which included R3, thus, E4 will be ordering FSBS three times a week effective immediately. 1/13/18 and timed 11:25 AM - A telephone verbal order was received from E4 for R3 to have FSBS 3 times a week on Monday at 6:30 AM, Wednesday at 6:30 PM and Friday at 6:30 PM. Findings were reviewed on 1/24/18 at approximately 4:15 PM with E1 (NHA), E2 (DON), E3 (CQS) and E7 (ADON TCU).	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		3/19/18

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F 686	Continued From page 30 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to provide treatment and services to promote healing of a pressure ulcer (PU) for one (R2) out of three sampled residents with PU. Upon readmission to the facility with a sacral PU, the facility failed to obtain treatment orders for R2's PU, instead reinstating previous treatment orders that should have been discontinued when R2 was discharged to the hospital. The facility failed to obtain new readmission treatment orders for R2's sacral PU for approximately 10 days. Additionally, the facility failed to comprehensively assess R2's sacral PU on a weekly basis. Findings include: 1a. The facility's policy titled Skin Integrity Care Delivery Process, dated 6/1/16, documented the following: The Skin Integrity Report (SIR) included assessment of the following characteristics of a PU: - PU stage; - Presence of pain; - Appearance; - Length (L);	F 686	1. R2 orders were written to reflect the residents needs for wound care. 2. Root cause: A. The center lacked a process for completion of SIR's weekly. B. The admitting nurse for R2 failed to write new orders and/or request new orders from the medical provider per policy. A. A skin sweep was completed by CNE, UM's and assigned nurse on current residents to determine current pressure injuries. Skin Integrity Reports (SIR) and physician orders were initiated/updated to accurately reflect the status of current wound(s). B. Re-admission medical records are being reviewed at each morning clinical meeting to validate new physician orders are written. 3.A. The licensed nursing staff will be educated on or before March 19, 2018 on	

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F 686	Continued From page 31 - Width (W); - Depth (D); - Undermining or Tunneling; - Drainage; - Surrounding Tissue; - Wound edges; - Odor. Review of R2's clinical record revealed: 10/11/17 - R2 was readmitted to the facility from the hospital. 10/11/17 - A readmission Nursing Assessment documented that R2 had a Stage II PU of the sacrum. 10/11/2017 - (last revision date, initially created 6/7/17) The care plan for risk of skin breakdown as evidenced by impaired sensation, incontinence, limited mobility, shear/friction risk, left sided weakness, and MASD documented that the resident will not show signs of skin breakdown x 90 days. In addition, that the skin irritation of the buttocks will heal within the next 90 days. Interventions included: - low air loss mattress (initiated 7/10/17); - turn and or/reposition and check skin every two hours (initiated 6/7/17); - weekly skin assessment by licensed nurse (initiated 6/7/17); - monitor skin for sign/symptoms of skin breakdown such as redness, cracking, blistering, decrease sensation, and skin that does not blanche easily; - Braden assessment per policy; - pressure redistribution surfaces to chair per protocol.	F 686	the SIR report, including assessment of the characteristics of a PU and the completion of the SIR. NEW PROCESS: Weekly SIR's will be added to the TAR to alert staff they are due for completion. B. Licensed nurses will be instructed that re-admissions will have new orders written according to the hospital discharge summary and verified by the medical provider. 4. A. The CNE/ADON/UM's will monitor 100% of re-admissions for compliance with new physician orders and completion of the SIR when PU(s) are identified upon admission times 3 months. B. The CNE/ADON/UM's will perform weekly wound rounds on 100% of residents with pressure ulcers to include reviewing of SIR's for three consecutive months. The CNE will report results to the QAPI committee monthly for further recommendations for sustainability of the plan.	

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F 686	Continued From page 32 Review of the record lacked evidence that a care plan for the actual sacral PU was developed. 10/11/17 - The SIR for R2's sacral PU, documented the onset date as 10/11/17, the day of R2's readmission from the hospital. This SIR documented the PU was a Stage II, with no pain, and a healing appearance with a L of 3 cm., W of 2 cm with no depth. There were no other characteristics regarding the PU documented. 10/20/17 - A SIR was completed, with documentation regarding each of the characteristics of the PU, indicating improvement including decreasing diameter. Record review lacked evidence that any additional weekly PU assessments were completed until 11/15/17, a total of three weeks. 11/15/17 - The SIR indicated an increase in L to 4.7 cm, W to 2.5 cm and depth of 0.1 cm with blooding drainage, healthy surrounding tissues, and no odor. There was no staging of the PU completed. Record review lacked evidence that any additional weekly PU assessments were completed until 12/13/17, a total of approximately 4 weeks. 12/13/17 - The SIR indicated R2's sacral PU had worsened to a Stage III. The assessment was incomplete with no information regarding appearance, L, W, D, surrounding tissue, wound edges, or odor. 12/14/17 - R2 was discharged to the hospital.	F 686		

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F 686	Continued From page 33 12/27/17 - R2 was readmitted to the facility after hospitalization. 12/27/17 - A SIR documented an unstageable sacral PU, with an onset date of 10/11/17. The documentation noted slough, 7 cm in L, 10 cm in W, and depth left blank (unable to determine depth due to presence of slough), minimum serosanguineous drainage with odor. Record review lacked evidence of any additional weekly assessments of R2's sacral PU for the next two (2) weeks. 1/11/18 - R2 was sent to the hospital ER for a blood transfusion. A hospital ER note documented R2's sacral PU was 8 cm. in diameter, with eschar in the center of the wound. 1/23/18 at approximately 3:00 PM - An interview with E2 (DON) was conducted. E2 verbalized that there were no additional weekly SIR assessments of R1's sacral PU available. E2 stated that there was no Wound Care Team, per se, during this period of time. 1/23/18 at approximately 4:00 PM - An interview with E1 (NHA) revealed that during the above period of time, there was no Wound Care Team to oversee and monitor PU management. E1 verbalized that the facility had identified the lack of weekly assessments recently and are in the process of acquiring resources for a Wound Care Team. 1b. The facility's policy titled Skin Integrity Care Delivery Process, dated 6/1/16, documented the following: Skin Integrity Impairment Identified:	F 686		

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F 686	Continued From page 34 12. Physician Provider Orders: -Obtain any needed orders. Review of R2's clinical record review revealed: 12/27/17 - R2 was readmitted to the facility from the hospital. 12/27/17 - Review of R2's readmission orders lacked evidence of a treatment order for the sacral PU. When a resident is admitted to a hospital, all facility orders are discontinued. Upon readmission to the facility, new physician's orders are required to be written for the resident, including any treatment orders. 12/28/17 - Review of the TAR lacked evidence of any treatment provided to R2's sacral PU. 12/29/17 through 1/8/18 - Review of the TAR revealed the facility was providing a treatment that had been ordered on 12/13/17, prior to R2's being discharged to the hospital on 12/14/17. This treatment consisted of cleaning the wound with wound cleanser, pat dry, skin prep around peri wound, apply Santyl to wound bed, and cover with 2 X 2 soaked with normal saline solution and cover with butterfly optifoam and skin prep around the edges daily. Record review lacked evidence of a physician's order for this treatment. As a result, treatment was completed without a valid physician's order. 1/8/17 - A physician's order was written to soak the sacral wound with Vashe solution times five minutes, apply Medihoney to wound and cover	F 686		

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F 686	Continued From page 35 with optilock daily. 1/23/18 at approximately 9:30 AM - An interview with E6 (ADON, LTC) confirmed the lack of readmission treatment orders for R2's sacral PU and that no treatment was provided on 12/28/17. E6 confirmed the facility restarted the 12/13/17 sacral wound care without a valid physician's order. Findings were reviewed on 1/24/18 at approximately 4:15 PM with E1 (NHA), E2 (DON), E3 (CQS) and E7 (ADON, TCU).	F 686		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure during a physician's visit, a review the resident's total program of care was conducted, including medications and treatments,	F 711	1. R1 no longer resides at the center since 9/9/2017. The center has no opportunity to correct.	3/19/18

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F 711	Continued From page 36 at each visit for one (R1) out of three sampled residents. Findings included: The following was reviewed in R1's clinical record: 1a. FINGERSTICK BLOOD SUGAR MONITORING: Cross refer F694, example 1a. 6/21/17 and timed 3:18 PM - A Follow-Up Progress Note, completed by E5 (NP2), notes changes in R1's plan of care as follows: -Discontinue routine Humalog insulin three times a day with meals. -Discontinue the SSI. -Accuchecks every AM and PM. 6/21/17 and untimed - Order written by E5, documented the following: -HbA1c on 12/15/17. -Discontinue SSI, discontinue Humalog 4 units SQ TID with meals. Despite notation in the 6/21/17 follow up progress note for accuchecks every AM and PM, E5 failed to write the order. 6/26/17 - A 30 day Follow-Up Note, completed by E5, documented FSBS every AM and PM, medication reviewed and reconciled with chart, reviewed medical records, labs and testing. Although E5 documented she had reviewed the total program of care for R1, E5 failed to identify that there was no order for FSBS every AM and PM. 6/28/17 - The MAR documented the order to check blood sugar before meals and at bedtime	F 711	2. Reference to F580 and F684 POC root cause. The center has reviewed the survey findings with Medical Director and Physician Extenders on 2/22/2018. The Physician/Physician Extenders will review Medical Records to determine that documentation of physician visits accurately reflect the residents status to include completion of orders. 3. The physician(s)and physician extenders will perform comprehensive and accurate medical record reviews to reconcile each medical record and document their findings to include A. Review of medications and doses. B. Ordered labs and results C. Review Glucose Management 4. The Medical Director will review physician visit documentation on 10 medical records monthly to determine accuracy of the following: A. Medications and doses are current B. Lab orders have been completed and noted in their documentation. C. Glucose management documentation reflects the current physician order. The audits will be completed for three consecutive reviews until 100% accuracy is achieved. The Medical Director will report findings of the clinical chart reviews to the QAPI committee monthly for further evaluations and recommendations to determine sustainability. If the center achieves 100% compliance this will be removed from monthly QAPI.	

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F 711	Continued From page 37 for diabetes mellitus was discontinued beginning on 6/28/17 at 4:00 PM. Although R1 was an insulin dependent diabetic, FSBS was discontinued in error and no further FSBS monitoring was occurring. 7/11/17 and timed 1:35 PM - A 30 day Follow-Up Note, completed by E5, documented follow-up related to diabetes and the plan was to discontinue Levemir insulin and discontinue Accucheck. Reviewed medical records, labs and testing. Again, E5 failed to identify that FSBS were not being done since the order was incorrectly discontinued on 6/28/17. 7/11/17 and timed 4:00 PM - An order written by E5, discontinued Levemir insulin and Accuchecks. 1/16/18 at approximately 3:00 PM - An interview with E5 revealed that she had documented on her progress note, to discontinue the SSI and to initiate FSBS Q AM and PM. E5 confirmed, through review of the closed records, there was no order written to check FSBS Q AM and PM when the order to discontinue SSI was written on 6/21/17. 1b. URINANALYSIS and URINE CULTURE AND SENSITIVITY: Cross refer F684, example 1b. 6/21/17 and timed 3:18 PM - A Follow-Up Progress Note, completed by E5, noted changes in R1's plan of care to include UA and urine C&S in AM due to patient complaints of urinary	F 711		

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F 711	Continued From page 38 urgency. 6/26/17 - A 30 day Follow-Up Note, completed by E5, documented UTI-UA and urine C&S pending. The note documented medical records, labs and testing were reviewed. Although record review lacked evidence that the order for the UA and urine C&S was implemented, the above note documented "pending." 7/11/17 and timed 1:35 PM - A 30 day Follow-Up Note, completed by E5, lacked documentation related to follow-up of the UA and urine C&S, despite notation that R1's medication was reviewed and reconciled with chart, reviewed medical records, labs and testing. 1/22/18 at approximately 3:15 PM - An interview with E5 revealed that she recalled that when she had asked the unit staff the status of the UA and urine C&S that was ordered on 6/21/17, she was informed that the results were pending. E5 related that there was system of tracking, that E5 could refer to to check on the status, instead she had relied on facility staff to update her on the status. E5 was advised, during this survey, that the facility lacked evidence the above orders were completed as ordered. E5 verbalized that she was not aware of this information until the time of the survey. 1c. REMERON: 6/1/17 through 6/30/17 - R1's physician orders lacked evidence of an order for Remeron 15 mg. PO Q HS.	F 711		

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F 711	Continued From page 39 6/26/17 - A 30 day Follow-up Note, completed by E5, documented that R1's current medication included Remeron 15 mg PO Q HS. The note documented R1's current medications were reviewed and reconciled with chart, reviewed medical records, labs and testing. 7/1/17 through 7/31/17 - R1's physician orders lacked evidence of an order for Remeron 15 mg. PO Q HS. 7/11/17 and timed 1:35 PM - A 30 day Follow-Up Note, completed by E5, documented R1's current medication included Remeron 15 mg PO Q HS. The note documented R1's current medications were reviewed and reconciled with the chart, reviewed medical records, labs and testing. 7/18/17 - An order was written by E5 for R1 to receive Remeron 7.5 mg. PO Q HS for depression and appetite stimulant. 1/16/18 at approximately 3:10 PM - An interview with E5 revealed that she had decreased the Remeron from 15 mg. to 7.5 mg. on 7/18/17. The surveyor informed E5 that record review revealed that there had never been an order written for R1 to receive Remeron prior to 7/18/17. Findings reviewed on 1/24/18 at approximately 4:15 PM with E1 (NHA), E2 (DON), E3 (CQS) and E7 (ADON, TCU).	F 711		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 790		3/19/18

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F 790	Continued From page 40 §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide or	F 790	1. R1 No longer resides in the center since 9/9/2017. The center has no	

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F 790	Continued From page 41 obtain from an outside dental services to meet the needs for one (R1) out of three sampled resident. Findings include: Cross refer F684, example #1. The following was reviewed in R1's clinical records: 6/21/17 and timed 3:18 PM - A Follow-up Progress Note, completed by E5 (NP2), documented the chief complaint/nature of presenting problem due to R1's swelling to the left cheek. Upon examination, the left cheek with swelling, buccal mucosa of left gum appears macerated with areas of dark discoloration. 6/21/17 and untimed - Orders written by E5 included an order for consultation with a dentist for the macerated left gum. The facility failed to identify and transcribe this order for seven (7) days, when a notation was made by E10 (LPN), "pulled and faxed 6/28/17." Record review lacked evidence of a dental consultation or an order to discontinue the consult. 1/16/18 at 12:05 PM - An interview with E2 (DON) revealed the facility failed to have evidence of a dental consultation. The surveyor inquired, did the facility have services available with a dentist, who provided onsite services at the facility when the order was obtained. E2 stated that she was uncertain. 1/16/18 at approximately 3:00 PM - An interview with E5 (NP2) revealed that it was her understanding, when the order was written, that	F 790	opportunity to correct. R1 received medical treatment from the physician with resolution to the problem. 2. Currently there are no emergency dental services needed. 3. Root Cause: Center was not contracted for in-house dental services. The center has coordinated and obtained routine and emergency dental services from an outside provider effective March 1, 2018. NPE educated Medical Director, physician/physician extenders, licensed nursing staff and social workers on the dental providers name and contact information for emergency dental services. 4. The CNE/ADON/UM's will review medical records at clinical morning meeting to determine physician orders for dental services requested have been scheduled. The review will be performed weekly times three months. The CNE(DON) will report findings to the QAPI committee monthly for further evaluations and recommendations to determine sustainability. If the center achieves 100% compliance this will be removed from monthly QAPI.	

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F 790	Continued From page 42 there was a dentist who was available to provide services at the facility, since R1's FM2 requested no out of facility appointments. E5 verbalized there was improvement noted with the antibiotic treatments and oral rinse. E5 stated that if there was no onsite dental consult available, she would have discontinued the order. 1/24/17 at approximately 3:25 PM - The surveyor received a telephone call from E1 (NHA), in response to the surveyor's inquiry on 1/23/18 whether on-site dental services were available when R1 had an order dated 6/21/17. E4 verbalized that her employment with the facility began in October 2017, but it was her understanding that there was no dentist available to provide the consult ordered on 6/21/17. Findings reviewed on 1/24/18 at approximately 4:15 PM with E1 (NHA), E2 (DON), E3 (CQS) and E7 (ADON, TCU).	F 790		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility's Medical Director (E4) failed to ensure the the implementation of resident care policies and the coordination of	F 841	1. Cross Refer to F580, F684 and F711. R1 no longer resides at the center since 9/9/2017. The center has no opportunity to correct.	3/19/18

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F 841	Continued From page 43 medical care in the facility. Findings include: 1. Cross refer F684, example 1a. The following interview was conducted during the survey, which revealed lack of coordination of care by the Medical Director (E4), related to monitoring of R1 and other diabetic residents. On 1/18/18 at approximately 1:00 PM, an interview with E4 was conducted and E4 was asked to review R1's 6/21/17 order to discontinue SSI. E4 verbalized the order was to discontinue the SSI only and not to discontinue checking the FSBS before meals and bedtime for R1. E4 related that there was a meeting held, on 8/17/17, as requested by family members, FM1 and FM2 inquiring the reason for the checking of the FSBS which was stopped on 6/28/17. Following this meeting, E4 had educated her medical providers in her group practice, E5 (NP2) and E19 (AP2), that all residents with diagnoses of diabetes mellitus, will be monitored via an individually determined monitoring schedule via FSBS in addition to the HbA1C. E4 stated that this expectation was not communicated to other providers, such as those providing medical care through a managed care program, however, this expectation was communicated to this separate group of medical providers during the survey on 1/13/18. 2. Cross refer 684, example 1b. The following interviews were conducted during the survey, which revealed lack of clear and consistent resident care expectations by the Medical Director (E4), related to Change In Condition of the residents in the facility.	F 841	2. Cross refer to F580, F684,and F711 for root cause. A. Center reviewed resident records during the survey of those who have a diagnosis of Diabetes Mellitus to determine current orders are in place for glucose monitoring and diabetic management. Review confirmed by surveyor. B. CIC(s) are being reviewed at each clinical meeting to determine documentation for monitoring and assessing residents, including vital signs for significant change in condition. 3. A. Center attending physician's/physician extenders were educated by the Medical Director in regards to orders for monitoring Glucose per patients needs. B. Physician and physician extenders and licensed nurses will be educated by the NPE that FSBS and Insulin orders are two separate provider orders. Licensed nurses will be educated by the NPE on the need for vital signs for a significant change in condition. 4. The CNE/ADON/UM's will meet monthly with Medical Director to review a minimum of 10 medical records for the next 6 months until 100% accuracy is obtained for the determination and coordination of medical care,and resident care policies are appropriate.	

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F 841	Continued From page 44 1/16/18 at approximately 3:00 PM - An interview was conducted with E5 (NP2). The surveyor inquired, what provisions of care and services should be provided by the staff, when R1 experienced a CIC, such as when R1 was place on antibiotic treatment. E5 verbalized it was her understanding, when a CIC occurs, clinical assessment and monitoring was required for 72 hours including full set of vital signs per shift. 1/18/18 at approximately 1:00 PM - An interview with E4 was conducted. As the Medical Director, it was her expectation and understanding for CIC, such as a resident on an antibiotic, the facility would complete full set of vital signs, every 8 hours while the resident is on an antibiotic and additional duration and frequency to be determined by the medical practitioner. 1/23/18 at approximately 3:00 PM - An interview with E2 (DON) was conducted. E2 stated that there was not a predetermined frequency and duration of monitoring, for those residents on antibiotic or who may have an infection, however, her minimum expectation would be obtaining a temperature. E2 indicated that the attending physician would order specific monitoring that would be required for each resident. In addition, E2 stated that each licensed nurse will utilize their own nursing judgement related to adequate monitoring. 1/23/18 at approximately 4:15 PM - During the exit meeting, E3 (CQS) confirmed that there was no facility policy and procedure, with predetermined frequency and duration of monitoring for various CIC like those experienced by R1, from June 2017 through August 2017. However, by standard of practice, the expectation	F 841		

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F 841	Continued From page 45 was temperatures be taken while a resident was being treated with an antibiotic. The surveyor verbalized the order for daily VS was not followed during this period, including temperatures. Findings reviewed on 1/24/18 at approximately 4:15 PM with E1 (NHA), E2, E3 (CQS) and E7 (ADON, TCU).	F 841		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation as indicated, it was determined that the facility's quality assessment and assurance program failed to identify issues related to lack of blood glucose monitoring for diabetic residents in the facility. Findings include: Cross refer F684, example 1a.	F 868	1. R1 no longer resides in the center as of 9/9/2017. The center has no opportunity to correct. 2. New Process. The performance improvement process is currently added and performed at administrative and clinical meetings to identify issues with	3/19/18

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F 868	Continued From page 46 Cross refer F580. Cross refer F841. The following interviews were conducted during the survey. The facility's quality assessment and assurance committee failed to identify lack of blood glucose monitoring for those residents who are diabetic. On 1/18/18 at approximately 1:00 PM, an interview with E4 (Medical Director) was conducted and E4 was asked to review R1's 6/21/17 order to discontinue SSI. E4 verbalized the order was to discontinue the SSI only and not to discontinue checking the FSBS before meals and bedtime for R1. E4 stated that she was aware, during a meeting requested by FM1 and FM2 (family members of R1) that the order led to the discontinuing the checking of the FSBS as well. E4 verbalized that this meeting was held on 8/17/17. Following this meeting, E4 had educated her medical providers in her group practice, E5 (NP2) and E19 (AP2), that all residents with diagnoses of diabetes mellitus, will be monitored via an individually determined schedule by checking FSBS, in addition to the HbA1C. E4 stated that this expectation was not communicated to other providers, such as those providing medical care through a managed care program, however, it was communicated to this separate group during the survey on 1/13/18. E4 reported that the facility's QAPI (Quality Assessment and Performance Improvement) committee met on a monthly basis, however, the contributing issues that may have led to the discontinuing of the checking of the FSBS, were not identified by the QAPI Committee and instead were identified at the time of the survey.	F 868	respect to quality assessment and assurance activities and determine the need for the development of an action plan. 3. Center Executive Director (CED) has added the QAPI process to the administrative and clinical meetings agenda that includes the participation of department managers and other key staff members. The CED will educate current department managers on OPS 103 Center Quality Improvement Process (QAPI) on or before 3/19/2018. The Nurse Educator will educate nursing, dietary, environmental services, maintenance, rehabilitation, and ancillary staff members on OPS 103 Center Quality Improvement Process. 4. The CED, CNE and the Medical Director has submitted this plan of correction for survey ending 1/23/2018 to the current QAPI committee beginning February 22, 2018. The CED will prioritize and determine the need for improvement projects and assist the staff in timely identification and coordination of action plans to be submitted to the QAPI committee monthly. The CED will meet monthly with Medical Director and the CNE to achieve sustainability with the new process.	

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F 868	Continued From page 47 1/23/18 at approximately 3:45 PM - An interview with E1 (NHA) revealed the facility's QAPI Committee met on a monthly basis. E1 was not able to provide evidence that the lack of ongoing and individualized monitoring via FSBS for residents with diabetes was identified when a concern was brought up by R1's family members FM1 and FM2 in a meeting. E1 stated that she began employment in October of 2017 and her predecessor, E20 (NHA) was the administrator on 8/17/17. Findings were reviewed on 1/24/18 at approximately 4:15 PM with E1, E2 (DON), E3 (CQS) and E7 (ADON, TCU).	F 868		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: January 23, 2018

STATEMENT OF DEFICIENCIES SECTION Specific Deficiencies		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint investigation survey was conducted at this facility from January 11, 2018 through January 23, 2018. The facility census the first day of the survey was 127. The survey sample totaled 8 residents.	Cross refer to CMS 2567-L Dated 1-23-18	3-14-18
3310	**Regulations for Skilled and Intermediate Care Facilities**		
3310.1.0	**Scope**		
3310.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed January 23, 2018, F580, F656, F684, F686, F711, F790, F841 and F868.		

Provider's Signature Kathleen A Dwire Title CED Date 2/25/18

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: January 23, 2018

STATEMENT OF DEFICIENCIES SECTION **Specific Deficiencies**	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature _____ Title _____ Date _____